Sample 837 Scenarios

The sample scenarios are for test and education purposes. The information is test data and does not represent actual insurance carriers, employers, injured employees, or health care providers. The information may appear to be real or confidential information. However, this is done in order to ensure the test data passes validation edits.

TX 837 – Scenario 11

Dental Bill

Darlene Davidson is a single female, born 06/04/69. She lives at 5720 Green Drive in Arlington, TX 62309. Her telephone number is (703) 836-5527 and social security number is 224-17-3272.

Darlene works at Bagels, Etc. located at 234 Main Street in Arlington, TX 62314. Bagels, Etc.'s telephone number is (703) 472-1462.

Bagels, Etc. is covered under policy number 147643A472 by WorkComp Insurance Company. WorkComp Insurance Company is located at 789 Airport Road in Austin. TX 60606-1234. Their telephone number is (312) 555-1470 and their FEIN is 98-7654321.

- On 08/29/04 Darlene fell down while working at Bagels, Etc. and broke two front teeth.
- On 08/29/04 Darlene went to Fix'em Up Dental Clinic for tooth repairs. She was seen by Dr. David Smith, license DS45687TX
- On 08/30/04 Fix'em Up Dental Clinic sent a bill for the services to WorkComp Insurance Company.
- On 09/04/04 WorkComp Insurance Company received an original bill for Darlene's tooth repairs from Fix'em Up Dental Clinic with charges totaling $1100.00:
    - 08/29/04 Surgical Rmvl-Erupted Tooth D7210 550.00
    - 08/29/04 Surgical Rmvl-Erupted Tooth D7210 550.00
- On 09/15/04 WorkComp Insurance Company mailed payment to Fix'em Up Dental Clinic in the amount of $515.62:
    - 08/29/04 Surgical Rmvl-Erupted Tooth D7210 257.81, using W1
    - 08/29/04 Surgical Rmvl-Erupted Tooth D7210 257.81, using W1

WorkComp Insurance Company is required to report all medical bill payment information to the Texas Workers' Compensation Commission (TWCC) within 30 days of payments made.

- On 10/01/04 WorkComp Insurance Company sent a transaction to TWCC covering the reporting period of 09/01/04 to 09/30/04. The unique bill number assigned by WorkComp Insurance Company for Darlene's bill was 111123.

ADA Dental Claim Form

HEADER INFORMATION

1. Type of Transaction (Check all applicable boxes)
   ☐ Statement of Actual Services OR ☐ Request for Predetermination /Preauthorization
   ☐ EPSDT/ Title XIX

2. Predetermination/Preauthorization Number
   65489

PRIMARY PAYER INFORMATION

3. Name, Address, City, State, Zip Code
   WorkComp Insurance Company
   789 Airport Road
   Austin, TX 60606-1234

OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Subscriber Name (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY)

7. Gender ☐ M ☐ F

8. Subscriber Identifier (SSN or ID#)

9. Plan/Group Number

10. Relationship to Primary Subscriber (Check applicable box)
    ☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Carrier Name, Address, City, State, Zip Code

PRIMARY SUBSCRIBER INFORMATION

12. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    Bagels, Etc.
    234 Main Street
    Arlington, TX 62314
    (703) 472-1462

13. Date of Birth (MM/DD/CCYY)

14. Gender ☐ M ☐ F

15. Subscriber Identifier (SSN or ID#)

16. Plan/Group Number

17. Employer Name

PATIENT INFORMATION

18. Relationship to Primary Subscriber (Check applicable box)
    ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other

19. Student Status ☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
    Darlene Davidson.
    5720 Green Drive
    Arlington, TX 62309
    (703) 836-5527

21. Date of Birth (MM/DD/CCYY)
    06/04/69

22. Gender ☐ M ☒ F

23. Patient ID/Account # (Assigned by Dentist)
    224-17-3272

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	30. Description	31. Fee
1	08/29/04			7		D7210	Surgical Rmvl-Erupted Tooth	550 00
2	08/29/04			9		D7210	Surgical Rmvl-Erupted Tooth	550 00
3								
4								
5								
6								
7								
8								
9								
10								

MISSING TEETH INFORMATION

34. (Place an 'X' on each missing tooth)

Permanent																Primary									
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	A	B	C	D	E	F	G	H	I	J
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	T	S	R	Q	P	O	N	M	L	K

32. Other Fee(s)

33. Total Fee 1100 00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X _____
Patient /Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X _____
Subscriber signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code
    Fix 'em Up Dental Clinic
    4550 Denture Drive
    Arlington, TX 62314

49. Provider ID
    569874520

50. License Number

51. SSN or TIN

52. Phone Number (703) 562-2689

ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment (Check applicable box)
    ☒ Provider's Office ☐ Hospital ☐ ECF ☐ Other

39. Number of Enclosures (00 to 99)
    Radiograph(s): 2 Oral Image(s): Model(s):

40. Is Treatment for Orthodontics?
    ☒ No (Skip 41-42) ☐ Yes (Complete 41-42)

41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining

43. Replacement of Prosthesis?
    ☐ No ☐ Yes (Complete 44)

44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from (Check applicable box)
    ☒ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) 08/29/04

47. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed and that the fees submitted are the actual fees I have charged and intend to collect for these procedures.
    David Smith, DDS 08/30/04

X _____
Signed (Treating Dentist) Date

54. Provider ID

55. License Number DS45687TX

56. Address, City, State, Zip Code
    4550 Denture Drive
    Arlington, TX 62314

57. Phone Number ( )

58. Treating Provider Specialty

J515 (Same as ADA Dental Claim Form) Ð J516, J517, J518, J519

Insurance Products Provided by Oregon Dental Service.